



**Greater Los Angeles
Coordinated Entry System**

Survey Packet

Version 2.2

CES Survey: Introduction

Thank you for taking time to know the name and needs of our homeless neighbors. The 20-30 minutes you will spend are invaluable to helping us understand the unique needs of the respondent and also the broader region in which he/she resides. Your engagement of the respondent and effective application of the following survey is a critical first step to ending homelessness in Greater Los Angeles. Thank you!

CONTENTS

- 1. Instructions (for Surveyor):** Brief guidelines for best application of this survey - further instructions are available at hmis.lahsa.org, under Provider Tools: Document Library and Video Library, and on the CES Website at www.HomeForGoodLA.org/ces (Forms & Resources)
- 2. Checklist:** A list of the steps involved in making the respondent eligible for referrals through CES.
- 3. Instructions (for Respondent):** A script of instructions to be read aloud to the respondent.
- 4. Consent:** Required form to gain legal permission to share respondent answers in Homeless Management Information System.
- 5. Part 1 (VI-SPDAT v2 and basic intake)**
Part 1 of the CES Survey features the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT v2). The VI-SPDAT is a triage tool designed to recommend the best type of permanent housing solution for someone experiencing homelessness. It is a holistic survey developed by OrgCode Consulting and Community Solutions and is written in a manner designed to be understood more easily by respondents. Part 1 of the survey also includes a set of basic intake and eligibility questions to help begin identifying resources and supports that the respondent may qualify for immediately.
- 6. Part 2 (Program Intake questions)**
The program intake assessment captures all additional data that is required when entering a program. This assessment should be completed when the client is entering into any homeless service program or upon engagement in outreach and assessment only programs.
- 7. Supplemental: VA**
The VA release of information should be filled out for any client that identifies as a US veteran. While typically the VA supplemental assessment is completed by VA staff, this can also be completed by the surveyor.. It does not have to be filled out exclusively by VA staff.
- 8. Supplemental: DHS (Housing for Health Referral Form)**
The Supplemental DHS referral should be filled out for any client that has two or more visits to a DHS facility.
- 9. Supplemental: Housing Preferences**
The supplemental housing preferences are a set of eligibility questions used to help make more appropriate referrals to housing opportunities. This was formerly known as the Matching Initiation Form.
- 10. Contact Sheet:** A sheet with follow-up contacts that you may wish to provide the respondent upon request.
- 11. Additional Consents (*If Provided):** Additional authorization, release and consent forms may be provided by your agency or coordinator to allow for seamless coordination with other supports or resources.

CES Survey: Introduction

INSTRUCTIONS FOR THE SURVEYOR ****Please do not read aloud****

- **THE CONSENT MUST BE COMPLETED AND SIGNED** (FOR HOUSEHOLDS, EVERY ADULT MEMBER MUST SIGN)
In the case that respondent refuses consent, or answering affirmatively in the domestic violence section, you may still proceed, however please note these special instructions: Do not enter Personal Identifiable Information (PII) into HMIS. HMIS will automatically generate an anonymous ID. Please retain at least the first page of CES Survey Part I (with HMIS ID & Client Name) for your records and future matches since you will not be required to enter identifying information into HMIS.
- **FOLLOW A MODEL OF PROGRESSIVE ENGAGEMENT.**
The various sections of the survey (Part 1, Part 2, and Supplemental sections) may be completed at one time or over various engagements, based on the comfort and preference of the respondent. Allow respondents to go at a pace that is comfortable for them. This may mean doing multiple sections, one section, or even just portion of a section.
- **REFERRALS AND NEXT STEPS.**
Initial eligibility questions for specific resources are located throughout the survey. Next steps are listed for these questions in the body of survey as well as in the office only section. Complete the next step (either a supplemental assessment or a referral) based on the comfortability and preference of the respondent.
- **RESERVE JUDGEMENT.**
Regardless of the outcome of the survey responses, please remain neutral in your response and reserve judgment and unsolicited advice.
- **DO NOT BE DISAPPOINTED IF THE RESPONDENT DOESN'T WANT TO BE SURVEYED.**
Negative experiences with past services may cause the respondent to be distrustful. Reversing course on that is a process, and your positive interaction and respect of their boundaries will help future engagements.
- **DO NOT PROMISE HOUSING OR SERVICES.**
Though you may be trying to be helpful, false promises will only add to their distrust and disinterest with future engagements.
- **DO NOT MANIPULATE RESPONSES.**
Major eligibility criteria are officially verified later so it does not benefit the respondent to be dishonest.
- **DO NOT VOLUNTEER THE SCORE OR THE SCORING PROCESS.**
You may share the general housing recommendation, but we do not want people being referred to as numbers.
- **YES AND NO ANSWERS ARE FINE, IDEAL EVEN. AVOID FOLLOW UP QUESTIONS.**
Respondents do not need to explain themselves. Explain questions if further clarification is needed, but try to keep the conversation short and clear to respect their time. Make note of items you may want to come back to, but allow engagement/case management to happen separate from the survey itself.
- **COUNT BACKWARDS AND PAUSE.**
For any question that asks a date range, count backward to the first date – so if today is January 1, 2015 and the questions asks “in the last 6 months,” say in “in the last 6 months...December, November, October, September, August, July. So since July 2014 ...” Also, for any question that states “anything like that,” add an intentional pause between “or anything (pause) like (pause) that” to help emphasize that you have read a list.
- **BE PREPARED TO EXPLAIN LENGTH OR QUESTIONS**
If a respondent finds a question offensive or is frustrated by the length, please explain that each question will help to avoid some inappropriate referrals and hopefully save them time in the long run. For other questions with more obvious answers, you may explain that you wanted to give them the ability to speak for themselves.
- **PRACTICE.**
As you become more comfortable with the survey, you should notice a gradual reduction in the amount of time it takes to complete.

CES Survey: Introduction

CHECKLIST

Prepare

- ☐ **Review:** Instructions for the Surveyor
- ☐ **Read Aloud:** Instructions for the Respondent
- ☐ **Request Signature:** Consent Form

Survey (portions may be completed together or at separate times)

- ☐ **Verbally Administer:** Survey Part 1 (VI-SPDAT v2, basic intake, initial eligibility questions)
- ☐ **Verbally Administer:** Survey Part 2 (Program Intake)
- ☐ **Verbally Administer*:** VA Release of Information; Supplemental: VA (if applicable; can be referred to VA staff)
- ☐ **Verbally Administer:** DHS Authorization for Use and Disclosure; Supplemental: DHS (Housing for Health Referral Form) (if applicable)
- ☐ **Verbally Administer:** Supplemental: Housing Preferences
- ☐ **Take picture:** Client may decline. Ask if you can take a picture of their ID instead or take a picture with them.
- ☐ **Provide:** Contact sheet if you or your coordinator are willing to be available for follow-up contact

Follow-Up

- ☐ **File Consent:** Keep record of consent and/or distribute to appropriate party in your SPA
 - ☐ **Data Entry:** Enter survey responses into HMIS
 - ☐ **Upload:** client picture, copies of documents, additional signed consents, to HMIS
- =====The following steps may be taken over by a Housing Navigator=====
- ☐ **Obtain Documents (*if not already in possession):** Birth Certificate, ID & Social Security. Although not immediately required, please be prepared to quickly prepare income verification documents as well.
Possessing documents required for housing is the final step in becoming "match-ready" for most housing in CES.
 - ☐ **Data Entry:** Note receipt of documents and upload scanned copy of documents into HMIS if possible.

CES Survey: Introduction

INSTRUCTIONS FOR RESPONDENT

Hello! My name is _____ and I am with a group called _____ (organization name). I have a survey I would like to complete with you.

- There are a few parts to this survey. The first part takes about 20-30 minutes to complete. Let's complete the first part and after that, we can see if we want to do more today, or wait for a different day.
- Most questions only require a "yes," "no" or other one-word answer. If you have more to share about an answer, I'd be happy to discuss that after the survey, but let's try and finish the survey first.
- This is not a housing application, but the answers will help us understand your health and housing needs and the needs of our community, and may help us make better referrals for you in the future.
- All that to say, I'm not using the answers you give to make any personal judgments about you.
- This survey is for anyone who is experiencing homelessness – not just people with a certain type of need.
- Some questions are personal in nature, but again, every question is designed to help us help you. You can skip or refuse any question that you don't feel comfortable answering, but the more questions you're willing to answer, the better.
- Someone may follow up with you to assist in getting documents needed to access resources, so it's important that we have accurate contact information for you.
- There is no need to take this survey twice, but from time to time we may want to update it with you, to make sure the information is accurate.
- Afterward, you may request a contact sheet and refer to it if you have questions.

Before we begin, I need to get your permission to do this survey with you. Please review the following form and let me know if you have any questions.

CES Survey: Consent

GREATER LOS ANGELES & ORANGE COUNTY

HOMELESS MANAGEMENT INFORMATION SYSTEM (LA/OC HMIS)

CONSENT TO SHARE PROTECTED PERSONAL INFORMATION

The LA/OC HMIS is a local electronic database that securely record information (data) about clients accessing housing and homeless services within the Greater Los Angeles and Orange Counties. This organization participates in the HMIS database and shares information with other organizations that use this database. This information is utilized to provide supportive services to you and your household members.

What information is shared in the HMIS database?

We share both Protected Personal Information (PPI) and general information obtained during your intake and assessment, which may include but is not limited to:

- Your name and your contact information
- Your social security number
- Your birthdate
- Your basic demographic information such as gender and race/ethnicity
- Your history of homelessness and housing (including your current housing status, and where and when you have accessed services)
- Your self-reported medical history, including any mental health and substance abuse issues
- Your case notes and services
- Your case manager's contact information
- Your income sources and amounts; and non-cash benefits
- Your veteran status
- Your disability status
- Your household composition
- Your emergency contact information
- Any history of domestic violence
- Your photo (optional)

How do you benefit from providing your information?

The information you provide for the HMIS database helps us coordinate the most effective services for you and your household members. By sharing your information, you may be able to avoid being screened more than once, get faster services, and minimize how many times you tell your 'story.' Collecting this information also gives us a better understanding of homelessness and the effectiveness of services in your local area.

Who can have access to your information?

Organizations that participate in the HMIS database can have access to your data. These organizations may include homeless service providers, housing groups, healthcare providers, and other appropriate service providers.

How is your personal information protected?

Your information is protected by the federal HMIS Privacy Standards and is secured by passwords and encryption technology. In addition, each participating organization has signed an agreement to maintain the security and confidentiality of the information. In some instances, when the participating organization is a health care organization, your information may be protected by the privacy standards of the Health Insurance Portability and Accountability Act (HIPAA).

CES Survey: Consent

By signing below, you understand and agree that:

- You have the right to receive services, even if you do not sign this consent form.
- You have the right to receive a copy of this consent form.
- Your consent permits any participating organization to add to or update your information in HMIS, without asking you to sign another consent form.
- This consent is valid for seven (7) years from the date the PPI was created or last changed.
- You may revoke your consent at any time, but your revocation must be provided either in writing or by completing the *Revocation of Consent* form. Upon receipt of your revocation, we will remove your PPI from the shared HMIS database and prevent further PPI from being added. The PPI that you previously authorized to be shared cannot be entirely removed from the HMIS database and will remain accessible to the limited number of organization(s) that provided you with direct services.
- The Privacy Notice for the LA/OC HMIS contains more detailed information about how your information may be used and disclosed. A copy of this notice is available upon request.
- No later than five (5) business days of your written request, we will provide you with:
 - A correction of inaccurate or incomplete PPI
 - A copy of your consent form
 - A copy of your HMIS records; and
 - A current list of participating organizations that have access to your HMIS data.
- Aggregate or statistical data that is released from the HMIS database will not disclose any of your PPI.
- You have the right to file a grievance against any organization whether or not you sign this consent.
- You are not waiving any rights protected under Federal and/or California law.

SIGNATURE AND ACKNOWLEDGEMENT

Your signature below indicates that you have read (or been read) this client consent form, have received answers to your questions, and you freely consent to have your information, and that of your minor children (if any), entered into the HMIS database. You also consent to share your information with other participating organizations as described in this consent form.

☐ **I consent to sharing my photograph. (Check here)**

Client Name: _____ DOB: _____ Last 4 digits of SS _____

Signature _____ Date _____

☐ **Head of Household (Check here)**

Minor Children (if any):

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

Client Name: _____ DOB: _____ Last 4 digits of SS _____ Living with you? (Y/N)

Print Name of Organization Staff

Print Name of Organization

Signature of Organization Staff

Date

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

Administration

First Name: _____ Last Name: _____

Program Name: _____ HMIS Consent: ☐ **System** ☐ Refused

Immediate Safety Assessment

Instructions for surveyor (DO NOT READ ALOUD): Due to the confidential nature of the following questions, we ask that you try to secure a private space where the **respondent is unaccompanied**. Regardless of the outcome, please remain neutral in your response and reserve judgment and unsolicited advice.

Question	Answer (Check One)	Comment
1. Are you seeking services today because you are concerned about your immediate safety related to abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	
2. If you experienced domestic or intimate partner violence, was this within the past month?	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> N/A	
3. Are you currently fleeing because you are in danger?	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> N/A	

If question #2 and #3 were both answered as "Yes", then refer the client to the LA County Domestic Violence Hotline: 1-800-978-3600

Basic Information

Name Data Quality: <i>Did the client provide their full name?</i> <input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, street name, or code name reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	Date of Birth: ____/____/____ <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	Social Security Number: ____-____-____ <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
If the person is 60 years of age or older, then score 1.		
Score: <div></div>		

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

A. History of Housing and Homelessness

Question	Answer (Check One)	Comment
4. Where do you sleep most frequently?	<input type="checkbox"/> Shelters <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Safe Haven <input type="checkbox"/> Outdoors <input type="checkbox"/> Other (please specify: _____)	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If the person answers anything other than "Shelters", "Transitional Housing", or "Safe Haven", then score 1.		Score: _____
5. How long has it been since you lived in permanent stable housing?	_____ Months	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
6. In the last three years, how many times have you been homeless?	_____ Episodes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If the person has experienced 1 or more consecutive years of homelessness, and/or 4+ episodes of homelessness, then score 1.		Score: _____

B. Risks

Question	Answer (Check One)	Comment
7. In the past six months, how many times have you...		
7a. Received health care at an emergency department / room?	_____ Times	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
7b. Taken an ambulance to the hospital?	_____ Times	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
7c. Been hospitalized as an inpatient?	_____ Times	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
7d. Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines?	_____ Times	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
7e. Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along?	_____ Times	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
7f. Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between?	_____ Times	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If the total number of interactions equals 4 or more, then score 1 for <i>Emergency Service Use</i> .		Score: _____
8. Have you been attacked or beaten up since you've become homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
9. Have you threatened to or tried to harm yourself or anyone else in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If "Yes" to any of the above, then score 1 for <i>Risk of Harm</i> .		Score: _____

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

10. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
If "Yes", then score 1 for Legal Issues.			Score: <input type="text"/>
11. Does anybody force or trick you to do things that you do not want to do?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
12. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
If "Yes" to any of the above, then score 1 for Risk of Exploitation.			Score: <input type="text"/>

C. Socialization & Daily Functioning

Question	Answer (Check One)	Comment
13. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
14. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If "Yes" to question 13 or "No" to question 14, then score 1 for Money Management.		
15. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If "No", then score 1 for Meaningful Daily Activity.		
16. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If "No", then score 1 for Self-Care.		
17. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If "Yes", then score 1 for Social Relationships.		

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

D. Wellness

Question	Answer (Check One)	Comment
18. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
19. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
20. If there was space available in a program, housing, or resources that specifically assists people that live with HIV or AIDS, would that be of interest to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
21. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
22. When you are sick or not feeling well, do you avoid getting help?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
23. FOR FEMALE RESPONDENTS ONLY: Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If "Yes" to any of the above, then score 1 for <i>Physical Health</i>.		Score: <input type="text"/>
24. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
25. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If "Yes" to any of the above, then score 1 for <i>Substance Use</i>.		Score: <input type="text"/>
26. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:		
26a. A mental health issue or concern?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
26b. A past head injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
26c. A learning disability, developmental disability, or other impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
27. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If "Yes" to any of the above, then score 1 for <i>Mental Health</i>.		Score: <input type="text"/>
If the respondent scored 1 for <i>Physical Health</i> and 1 for <i>Substance Use</i> and 1 for <i>Mental Health</i>, score 1 for <i>Tri-Morbidity</i>.		Score: <input type="text"/>

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

28. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
29. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

If "Yes" to any of the above, then score 1 for <i>Medications</i> .	Score:
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30. YES OR NO: Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
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If "Yes", then score 1 for <i>Abuse and Trauma</i> .	Score:
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Follow-Up Questions

Question	Answer (Check One)	Comment
31. On a regular day...		
31a. Where is it easiest to find you?		
31b. What time of day is easiest to do so?		
32. So that someone can safely get in touch with you or leave you a message...		
32a. Is there a phone number?		
32b. Is there an email address?		
33. Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Refused

Contact Type (Who is the best person to get in touch with you?)	Phone Number	Phone Type	Email
Contact #1 First Name: _____ Last Name: _____ Relationship: <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Social Service Contact <input type="checkbox"/> Case Manager Contact	(____)____-____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message Center	
Contact #2 First Name: _____ Last Name: _____ Relationship: <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Social Service Contact <input type="checkbox"/> Case Manager Contact	(____)____-____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message Center	

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

Residency & Preferences

Question	Check One Answer	Comments
34. What city within the County of Los Angeles do you live in? <i>*SURVEYOR NOTE: Please choose a city from the Location of Survey list on page 10-12</i>	_____	
If question #34 was answered as Los Angeles, then the following question is required :		
34a. If you reside within the City of Los Angeles, in which community do you live in? <i>*SURVEYOR NOTE: Please choose a community from the Location of Survey list on page 10-12</i>	_____	
35. What other cities have you called home within the last year (last 12 months)? <i>*SURVEYOR NOTE: Please choose a city / cities from the Location of Survey list on page 10-12</i>	_____ _____ _____	
If either question #34 or #35 was answered as Long Beach or Santa Monica, then the following question is required :		
35a. How many months have you stayed in that city/community?	_____ months	
36. Is the region where you're currently residing where you're looking to be housed? <i>*SURVEYOR NOTE: location may be different from answer to Q35/35a</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No, I have another community in mind**	
If question #36 was answered as No (**), then the following question is required :		
36a. What is the community you are looking to be housed in? <i>*SURVEYOR NOTE: Please check ONLY ONE SPA.</i>	<input type="checkbox"/> SPA 1 – Antelope Valley <input type="checkbox"/> SPA 2 – San Fernando Valley <input type="checkbox"/> SPA 3 – San Gabriel Valley <input type="checkbox"/> SPA 4 – Metro/Central LA <input type="checkbox"/> SPA 5 – West LA <input type="checkbox"/> SPA 6 – South LA <input type="checkbox"/> SPA 7 – Southeast / East LA <input type="checkbox"/> SPA 8 – South Bay <input type="checkbox"/> Outside of LA County	
37. Would you be interested in housing options such as shared housing, a room for rent, or sober living?	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused	

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

US Department of Veterans Affairs (VA), Department of Mental Health (DMH), and Department of Health Services (DHS)

Have you ever served in the U.S. Military? (Veteran)				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected

Question	Check One Answer	Comments
38. To the best of your knowledge, do you think you are VA Healthcare eligible?	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	

If "Yes" to Veteran, administer VA release of information and refer to a veteran service provider to perform the "Supplemental – VA" assessment. Optional: complete the "Supplement – VA" assessment.

39. Are you currently receiving or have you ever received treatment at a mental health program/clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	
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39a. If yes, what is the name of the program/clinic?

40. Have you been a patient at any of the following county* hospitals, clinics, or health centers in the past 12 months? (*County refers to LA County Department of Health Services. If other, please state the name of the specific DHS Health Center.) <i>Please check all that apply</i>	<input type="checkbox"/> Does not receive care at any DHS hospital or clinic	
	<div> Hospitals <ul style="list-style-type: none"> <input type="checkbox"/> LAC + USC Med Center <input type="checkbox"/> Harbor UCLA Med Center <input type="checkbox"/> Olive View Med Center <input type="checkbox"/> Rancho Los Amigos </div> <div> Multi-Service Ambulatory Care Centers <ul style="list-style-type: none"> <input type="checkbox"/> Martin Luther King, Jr. Outpatient Center <input type="checkbox"/> High Desert Regional Health Center </div> <div> Comprehensive Health Centers <ul style="list-style-type: none"> <input type="checkbox"/> El Monte Comprehensive Health Center <input type="checkbox"/> Edward R. Roybal Comprehensive Health Center <input type="checkbox"/> H. Claude Hudson Comprehensive Health Center <input type="checkbox"/> Hubert H. Humphrey Comprehensive Health Center <input type="checkbox"/> Long Beach Comprehensive Health Center <input type="checkbox"/> Mid-Valley Comprehensive Health Center </div> <div> Health Centers <ul style="list-style-type: none"> <input type="checkbox"/> Antelope Valley Health Center <input type="checkbox"/> Bellflower Health Center <input type="checkbox"/> Dollarhide Health Center <input type="checkbox"/> Glendale Health Center <input type="checkbox"/> La Puente Health Center <input type="checkbox"/> Lake Los Angeles Health Center <input type="checkbox"/> Little Rock Health Center <input type="checkbox"/> San Fernando Health Center <input type="checkbox"/> South Antelope Valley Health Center <input type="checkbox"/> Wilmington Health Center </div> <div> Other <ul style="list-style-type: none"> <input type="checkbox"/> Other DHS clinic (Specify): </div>	

If any hospital or center was answered for question #40, then the following question is **required**:

40a. How many times have you accessed services at the DHS site(s) in the last 12 months?	<input type="checkbox"/> 1 <input type="checkbox"/> 6 <input type="checkbox"/> 2 <input type="checkbox"/> 7 <input type="checkbox"/> 3 <input type="checkbox"/> More than 7 <input type="checkbox"/> 4 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> 5 <input type="checkbox"/> Client Refused	
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If 2 or more to question 40a, perform the "Supplemental – DHS (Housing for Health Referral)" assessment

Demographics

Gender:	Ethnicity:	Race (Check All that Apply):	Residency Status:
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Doesn't identify as male, female, or transgender <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Citizen <input type="checkbox"/> Permanent Legal Resident <input type="checkbox"/> Asylee, Refugee, or other Eligible Immigrant <input type="checkbox"/> Ineligible Immigrant <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

Question	Check All That Apply	Comments
41. Do you think you might have any of the following conditions?	<input type="checkbox"/> Substance abuse disorder <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Physical disability <input type="checkbox"/> None of the above <input type="checkbox"/> Mental health disability <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Developmental disability <input type="checkbox"/> Client Refused <input type="checkbox"/> Chronic physical illness	

Income and Insurance

Income Source (Check all that apply): What sources of income do you have? If you received housing, how would you pay for things like food and utilities?	Stated Income: How much do you get?	Pay Interval: How often do you get it?					
		Weekly	Every Other Week	Twice A Month	Monthly	Quarterly	Yearly
<input type="checkbox"/> No financial resources	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Earned Income (employment wages / cash)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Workers Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Temporary Assistance for Needy Families (CalWorks)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> General Assistance (GA) / General Relief (GR)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pension or retirement income from a former job	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child Support	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alimony and other spousal support	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Source (Specify: _____)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Client Doesn't Know							
<input type="checkbox"/> Client Refused							
<input type="checkbox"/> Data not Collected							

Health Insurance (Check all that apply):				
<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected	
<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> State Children's Health	<input type="checkbox"/> VA Medical	<input type="checkbox"/> Indian Health Services Program
<input type="checkbox"/> Employer Provided	<input type="checkbox"/> COBRA	<input type="checkbox"/> Private Health Insurance	<input type="checkbox"/> Services	<input type="checkbox"/> Other: _____

Health Insurance Provider (Check all that apply):					
<input type="checkbox"/> Health Net	<input type="checkbox"/> My Health LA (DHS)	<input type="checkbox"/> Kaiser Permanente	<input type="checkbox"/> Care 1st Health Plan	<input type="checkbox"/> Other	<input type="checkbox"/> None
<input type="checkbox"/> Molina	<input type="checkbox"/> Anthem Blue Cross	<input type="checkbox"/> VA	<input type="checkbox"/> L.A. Care	<input type="checkbox"/> Unknown	

Housing History

Question	Check One Answer	Comments
42. Have you been evicted from a Public Housing Authority unit?	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	
43. Have you ever been convicted of manufacturing or producing methamphetamine?	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	
44. Are you required to register as a sex offender?	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

Office Use Only – Next Steps

Contact Type	Phone Number	Phone Type	Email
Housing Navigator <input type="checkbox"/> Same as Interviewer <input type="checkbox"/> Not Yet Assigned First Name: _____ Last Name: _____ Program: _____	(____)____-_____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message Center	

Question	Check One	Next Step
Potential Chronic Homelessness: Is respondent potentially chronically homeless based on the following: <input type="checkbox"/> History of Homelessness: Question #5 is 12 months or more, or Question #6 is 4 episodes or more <input type="checkbox"/> Disability: Scored 1 point in Substance Use, or Scored 1 point in Mental Health, or At least one disability is identified in question #41, or Question #18, #19, #20, or #39 is Yes If the two boxes above are checked, then the respondent is potentially chronically homeless.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Informs potential housing eligibility.
Potential Veteran: Did respondent answer “Yes” to Veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Administer VA release of information and refer to a veteran service provider to perform the “Supplemental – VA” assessment. Optional: Perform the “Supplement – VA” assessment.
Potential Health Services: Did respondent answer 2 or more to question #40a?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Perform the “Supplemental – DHS (Housing for Health Referral)” assessment
Domestic Violence: Did respondent answer “yes” to question #2 and #3?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Refer the client to the LA County Domestic Violence Hotline: <u>1-800-978-3600</u>

Domain	Subtotal	Results	
Pre-Survey	/ 1	Score:	Recommendation:
A. History of Housing & Homelessness	/ 2	0 – 3	No housing intervention
B. Risks	/ 4	4 – 7	An assessment for Rapid Re-Housing
C. Socialization & Daily Functions	/ 4	8 +	An assessment for Permanent Supportive Housing/Housing First
D. Wellness	/ 6		
Grand Total:	/ 17		

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

Interviewer's Name: _____ Organization: _____

Email: _____ Phone: _____

Date Survey Was Conducted: Date: ____ / ____ / ____

Location of Survey (*Please update later if respondent is later attached to Housing Navigator in a different Region)			
SPA	Region	City / Community	
<input type="checkbox"/> SPA 1 - Antelope Valley	<input type="checkbox"/> Lancaster	<input type="checkbox"/> Lancaster	
	<input type="checkbox"/> Palmdale	<input type="checkbox"/> Palmdale	
	<input type="checkbox"/> Other	<input type="checkbox"/> Other	
<input type="checkbox"/> SPA 2 - San Fernando Valley	<input type="checkbox"/> North	<input type="checkbox"/> Santa Clarita	<input type="checkbox"/> Castaic
		<input type="checkbox"/> Saugus	<input type="checkbox"/> Valencia
		<input type="checkbox"/> Newhall	<input type="checkbox"/> Val Verde
		<input type="checkbox"/> Canyon Country	<input type="checkbox"/> San Fernando
		<input type="checkbox"/> Granada Hills	<input type="checkbox"/> Sand Canyon
	<input type="checkbox"/> Sylmar		
<input type="checkbox"/> SPA 2 - San Fernando Valley	<input type="checkbox"/> West	<input type="checkbox"/> Woodland Hills	<input type="checkbox"/> Canoga Park
		<input type="checkbox"/> Winnetka	<input type="checkbox"/> West Hills
		<input type="checkbox"/> Calabasas	<input type="checkbox"/> Westlake Village
		<input type="checkbox"/> Agoura Hills	<input type="checkbox"/> Hidden Hills
		<input type="checkbox"/> Chatsworth	<input type="checkbox"/> Tarzana
	<input type="checkbox"/> Reseda	<input type="checkbox"/> Warner Center	
	<input type="checkbox"/> Porter Ranch		
<input type="checkbox"/> SPA 2 - San Fernando Valley	<input type="checkbox"/> Central	<input type="checkbox"/> Van Nuys	<input type="checkbox"/> Panorama City
		<input type="checkbox"/> Lake Balboa	<input type="checkbox"/> Studio City
		<input type="checkbox"/> Valley Glen	<input type="checkbox"/> Valley Village
		<input type="checkbox"/> Sherman Oaks	<input type="checkbox"/> Northridge
		<input type="checkbox"/> Encino	<input type="checkbox"/> North Hills
<input type="checkbox"/> SPA 2 - San Fernando Valley	<input type="checkbox"/> East	<input type="checkbox"/> North Hollywood	<input type="checkbox"/> Arleta
		<input type="checkbox"/> Sunland	<input type="checkbox"/> Lakeview Terrace
		<input type="checkbox"/> Tujunga	<input type="checkbox"/> Mission Hills
		<input type="checkbox"/> Pacoima	<input type="checkbox"/> Granada Hills
		<input type="checkbox"/> Shadow Hills	<input type="checkbox"/> Sun Valley
<input type="checkbox"/> SPA 2 - San Fernando Valley	<input type="checkbox"/> Glendale	<input type="checkbox"/> Burbank	<input type="checkbox"/> Glendale
		<input type="checkbox"/> Universal City	<input type="checkbox"/> Flintridge
		<input type="checkbox"/> La Crescenta	<input type="checkbox"/> Toluca Lake
		<input type="checkbox"/> La Canada	
<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> West	<input type="checkbox"/> Pasadena	<input type="checkbox"/> Monrovia
		<input type="checkbox"/> Altadena	<input type="checkbox"/> Arcadia
<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> San Marino	<input type="checkbox"/> San Gabriel	<input type="checkbox"/> Monterey Park
		<input type="checkbox"/> South Pasadena	<input type="checkbox"/> Duarte
<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> Alhambra	<input type="checkbox"/> Sierra Madre	<input type="checkbox"/> Bradbury
		<input type="checkbox"/> El Monte	<input type="checkbox"/> West Covina
<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> Central	<input type="checkbox"/> South El Monte	<input type="checkbox"/> La Puente
		<input type="checkbox"/> Irwindale	<input type="checkbox"/> Rosemead
<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> Baldwin Park	<input type="checkbox"/> Temple City	<input type="checkbox"/> Hacienda Heights
		<input type="checkbox"/> Azusa	<input type="checkbox"/> Glendora
<input type="checkbox"/> SPA 3 - San Gabriel Valley	<input type="checkbox"/> Covina		

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

<input type="checkbox"/> SPA 3 – San Gabriel Valley	<input type="checkbox"/> East	<input type="checkbox"/> San Dimas <input type="checkbox"/> La Verne <input type="checkbox"/> Claremont <input type="checkbox"/> Pomona	<input type="checkbox"/> Diamond Bar <input type="checkbox"/> Walnut <input type="checkbox"/> Industry
<input type="checkbox"/> SPA 4 – Metro/Central LA	<input type="checkbox"/> Downtown	<input type="checkbox"/> Downtown	
	<input type="checkbox"/> Hollywood	<input type="checkbox"/> Hollywood <input type="checkbox"/> East Hollywood <input type="checkbox"/> Los Feliz	<input type="checkbox"/> Hollywood Hills <input type="checkbox"/> West Hollywood
	<input type="checkbox"/> North East LA	<input type="checkbox"/> Eagle Rock <input type="checkbox"/> El Sereno <input type="checkbox"/> Glassell Park <input type="checkbox"/> Cypress Park <input type="checkbox"/> Lincoln Heights <input type="checkbox"/> Montecito Heights <input type="checkbox"/> Chinatown <input type="checkbox"/> Hermon	<input type="checkbox"/> Mount Olympus <input type="checkbox"/> Highland Park <input type="checkbox"/> Monterey Hills <input type="checkbox"/> Atwater Village <input type="checkbox"/> Mount Washington <input type="checkbox"/> Boyle Heights <input type="checkbox"/> East LA
	<input type="checkbox"/> Silverlake/Westlake Central	<input type="checkbox"/> Silverlake <input type="checkbox"/> Westlake <input type="checkbox"/> Korea Town	<input type="checkbox"/> Echo Park <input type="checkbox"/> Pico Union
	<input type="checkbox"/> Mid-Wilshire	<input type="checkbox"/> Park La Brea <input type="checkbox"/> Hancock Park <input type="checkbox"/> Larchmont District <input type="checkbox"/> Wilshire	<input type="checkbox"/> Mid-City <input type="checkbox"/> West Mid-City <input type="checkbox"/> Miracle Mile
<input type="checkbox"/> SPA 5 - West LA	<input type="checkbox"/> West LA	<input type="checkbox"/> Bel Air <input type="checkbox"/> Beverly Hills <input type="checkbox"/> Beverly Crest <input type="checkbox"/> Beverly Glen <input type="checkbox"/> Brentwood <input type="checkbox"/> Century City <input type="checkbox"/> Holmby Hills <input type="checkbox"/> Pacific Palisades <input type="checkbox"/> Malibu <input type="checkbox"/> Marina Del Rey <input type="checkbox"/> Manchester	<input type="checkbox"/> Santa Monica <input type="checkbox"/> Venice <input type="checkbox"/> Westchester <input type="checkbox"/> Westwood <input type="checkbox"/> Culver City <input type="checkbox"/> Palms <input type="checkbox"/> Rancho Park <input type="checkbox"/> South Robertson <input type="checkbox"/> Laurel Canyon <input type="checkbox"/> Mar Vista
<input type="checkbox"/> SPA 6 - South LA	<input type="checkbox"/> South	<input type="checkbox"/> Compton <input type="checkbox"/> Florence <input type="checkbox"/> South Central <input type="checkbox"/> South Los Angeles	<input type="checkbox"/> Rosewood <input type="checkbox"/> Willowbrook <input type="checkbox"/> Watts
	<input type="checkbox"/> North	<input type="checkbox"/> Crenshaw <input type="checkbox"/> Jefferson Park <input type="checkbox"/> University Park <input type="checkbox"/> Ladera Heights <input type="checkbox"/> West Adams	<input type="checkbox"/> Baldwin Hills <input type="checkbox"/> Leimert Park <input type="checkbox"/> Vermont <input type="checkbox"/> West Adams
	<input type="checkbox"/> South East	<input type="checkbox"/> Lynwood	<input type="checkbox"/> Paramount
	<input type="checkbox"/> West	<input type="checkbox"/> Hyde Park	<input type="checkbox"/> Windsor Hills
<input type="checkbox"/> SPA 7 - Southeast / East LA	<input type="checkbox"/> LCA 1: Central	<input type="checkbox"/> Bell <input type="checkbox"/> Bell Gardens <input type="checkbox"/> Commerce <input type="checkbox"/> Cudahy <input type="checkbox"/> Huntington Park	<input type="checkbox"/> Maywood <input type="checkbox"/> South Gate <input type="checkbox"/> Vernon <input type="checkbox"/> County Unincorporated

CES Survey Part 1: VI-SPDAT, Basic Intake

Client Name / HMIS ID: _____

<input type="checkbox"/> SPA 7 - Southeast / East LA	<input type="checkbox"/> LCA 2: North	<input type="checkbox"/> La Mirada <input type="checkbox"/> La Habra Heights <input type="checkbox"/> Montebello <input type="checkbox"/> Pico Rivera	<input type="checkbox"/> Santa Fe Springs <input type="checkbox"/> Whittier <input type="checkbox"/> County Unincorporated
	<input type="checkbox"/> LCA 3: South	<input type="checkbox"/> Artesia <input type="checkbox"/> Bellflower <input type="checkbox"/> Cerritos	<input type="checkbox"/> Downey <input type="checkbox"/> Norwalk <input type="checkbox"/> County Unincorporated
	<input type="checkbox"/> LCA 4: Long Beach	<input type="checkbox"/> Hawaiian Gardens <input type="checkbox"/> Lakewood	<input type="checkbox"/> Signal Hill <input type="checkbox"/> County Unincorporated
<input type="checkbox"/> SPA 8 - South Bay	<input type="checkbox"/> Harbor Area	<input type="checkbox"/> Harbor City <input type="checkbox"/> Harbor Gateway <input type="checkbox"/> Wilmington <input type="checkbox"/> San Pedro <input type="checkbox"/> Carson <input type="checkbox"/> Rolling Hills	<input type="checkbox"/> West Carson <input type="checkbox"/> Torrance <input type="checkbox"/> Lomita <input type="checkbox"/> Palos Verdes Cities <input type="checkbox"/> Avalon
	<input type="checkbox"/> North	<input type="checkbox"/> Inglewood <input type="checkbox"/> Lennox <input type="checkbox"/> West Athens <input type="checkbox"/> Del Aire <input type="checkbox"/> Hawthorne	<input type="checkbox"/> Gardena <input type="checkbox"/> Lawndale <input type="checkbox"/> Alondra Park <input type="checkbox"/> El Segundo
	<input type="checkbox"/> Long Beach	<input type="checkbox"/> Long Beach	
	<input type="checkbox"/> Beach Cities	<input type="checkbox"/> Hermosa Beach <input type="checkbox"/> Manhattan Beach	<input type="checkbox"/> Redondo Beach

ADDITIONAL SURVEYOR OBSERVATIONS

May include observations about client or location, such as description of make-shift shelter, detailed description of vehicle (if respondent was residing in vehicle)

End of CES Survey Part 1

CES Survey Part 2: Program Intake

Client Name / HMIS ID: _____

Client Information (All fields required unless noted otherwise)

Last Known Permanent Address (Optional):	Housing Status:	Family Type:
City: _____ State: _____ Zip: _____	<input type="checkbox"/> Category 1 – Homeless <input type="checkbox"/> Category 2 – At Imminent Risk of Losing Housing (within 14 days or less) <input type="checkbox"/> Category 3 – Homeless only under other Federal Statutes <input type="checkbox"/> Category 4 – Fleeing Domestic Violence <input type="checkbox"/> At Risk of Homelessness <input type="checkbox"/> Stably Housed <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Unaccompanied <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parents <input type="checkbox"/> Adults No children

Relation (to Head of Household completing survey)	Are you disabled?	What is the highest level of education you've completed?
<input type="checkbox"/> Self (Head of household) <input type="checkbox"/> Head of Household's Child <input type="checkbox"/> Head of Household's Spouse or Partner <input type="checkbox"/> Head of Household's other Relation Member <input type="checkbox"/> Other: Non-relation Member	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Less than Grade 5 <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grade 12 / High school diploma <input type="checkbox"/> School program does not have grade levels <input type="checkbox"/> GED <input type="checkbox"/> Some college <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Vocational certification <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

Income Information (All fields required unless noted otherwise)

Income Documentation (Optional): Do you have documents that verify income?	Comments (Optional):
<input type="checkbox"/> GR Form <input type="checkbox"/> Pay Stub <input type="checkbox"/> Utility Allowance <input type="checkbox"/> Child Support Forms <input type="checkbox"/> Social Security Forms <input type="checkbox"/> SSI Forms <input type="checkbox"/> CalWORKs Form <input type="checkbox"/> Unemployment Insurance Forms <input type="checkbox"/> W-2 Forms <input type="checkbox"/> SSDI Form <input type="checkbox"/> Workmans Comp <input type="checkbox"/> Self Employment Docs <input type="checkbox"/> Pension Letter/Stub <input type="checkbox"/> Unemployment Forms <input type="checkbox"/> Self Declaration <input type="checkbox"/> Employer Printout/Letter <input type="checkbox"/> VA Documentation	

Non-Cash Benefits (Check all that apply): What non-cash benefits do you receive?			
<input type="checkbox"/> None <input type="checkbox"/> Food Stamps (CalFresh) Amount: _____ <input type="checkbox"/> WIC	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> CalWORKs Child Care <input type="checkbox"/> CalWORKs Transportation <input type="checkbox"/> Other CalWORKs-Funded Services	<input type="checkbox"/> Client Refused <input type="checkbox"/> Temporary Rental Assistance <input type="checkbox"/> Section 8 or Rental Assistance <input type="checkbox"/> Other _____	<input type="checkbox"/> Data not Collected <input type="checkbox"/> Medically Needy Amount: _____

Documentation (Optional)

(Check all that are in the client's possession)	Expiration Date: (If applicable)	(Check all that are in the client's possession)	Expiration Date: (If applicable)
<input type="checkbox"/> Birth Certificate		<input type="checkbox"/> Social Security Card	
<input type="checkbox"/> Certificate of Disability		<input type="checkbox"/> TB Certification	
<input type="checkbox"/> DD214 (Veterans Only)		<input type="checkbox"/> Verification of Income	
<input type="checkbox"/> Driver's License / CA ID		<input type="checkbox"/> VA Release	
<input type="checkbox"/> Homeless Verification		<input type="checkbox"/> LACDMH 677 Authorization Consent	
<input type="checkbox"/> Proof of Residency		<input type="checkbox"/> DHS Pre-release	
<input type="checkbox"/> Reference Letter		<input type="checkbox"/> Other:	

CES Survey Part 2: Program Intake

Client Name / HMIS ID: _____

HOMELESSNESS – Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded

FOR ALL PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH:

1. What was the situation you were living in immediately prior to project entry? (Type of residence)	2. How long was the client staying in that place? (Length of stay in prior living situation)	3. Did the client stay less than...
Literally Homeless Situations <ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing 	For literally homeless situations: <ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected 	Not Applicable Go to question 6
Institutional Situations <ul style="list-style-type: none"> <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center 	For institutional situations: <ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected 	90 days: <ul style="list-style-type: none"> <input type="checkbox"/> Yes Go to question 6 <input type="checkbox"/> No Go to question 10
Transitional & Permanent Housing Situations <ul style="list-style-type: none"> <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing for formerly homeless persons <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) 	For transitional & permanent housing situations: <ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected 	7 nights: <ul style="list-style-type: none"> <input type="checkbox"/> Yes Go to question 6 <input type="checkbox"/> No Go to question 10
Other <ul style="list-style-type: none"> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected 		

CES Survey Part 2: Program Intake

Client Name / HMIS ID: _____

FOR EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH PROJECTS:

Question	Check One Answer	Comments
4. What was the situation you were living in immediately prior to project entry? <i>(Type of residence)</i>	<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing for formerly homeless persons <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	
5. How long was the client staying in that place? <i>(Length of stay in prior living situation)</i>	<div> <input type="checkbox"/> One night or less <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> Two to six nights <input type="checkbox"/> Client refused </div> <div> <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> Data not collected </div> <div> <input type="checkbox"/> One month or more, but less than 90 days </div> <div> <input type="checkbox"/> 90 days or more, but less than one year </div> <div> <input type="checkbox"/> One year or longer </div>	

After answering question 5, go to question 7

If the client is coming from an institution after having stayed less than 90 days or if the client is coming from a transitional, permanent, or other situation after having stayed less than 7 nights, then the following question is required:

Question	Check One Answer	Comments
6. On the night before your current housing situation, did you stay on the streets, in an emergency shelter, or at a safe haven?	<input type="checkbox"/> No <input type="checkbox"/> Yes <div> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected </div>	

If the project being entered is an emergency shelter, safe haven, or street outreach, or if the client answered questions #4 and #5, then the following questions are required:

Question	Check One Answer	Comments
7. What approximate date did you start living on the streets, emergency shelter, or safe haven? <i>(Approximate date started)</i>	<div> <div>_____</div> <div>/</div> <div>_____</div> <div>/</div> <div>_____</div> </div>	

CES Survey Part 2: Program Intake

Client Name / HMIS ID: _____

<p>8. In the past three years, how many times have you returned to the streets, an emergency shelter, or a safe haven after being housed? (Number of times the client has been on the streets, in ES, or SH in the past three years including today)</p>	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times <input type="checkbox"/> Four or more times	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>9. In those three years, what is the total number of months spent homeless on the streets, in an emergency shelter, or in a safe haven? (Total number of months homeless on the street, in ES, or SH in the past three years)</p>	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 months	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

Continue for all clients:

Question	Check One Answer	Comments
<p>10. Have you been diagnosed with AIDS or have you tested positive for HIV?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
<p>If question #10 was answered as "Yes" (**), then the following questions are required:</p>		
<p>10a. Do you expect this to substantially impair your ability to live independently?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
<p>10b. Do you have documentation of the disability and severity on file?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<p>10c. Are you currently receiving services or treatment for this condition?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
<p>11. Do you have a chronic health condition? A Chronic Health Condition is defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to: heart disease (including coronary heart disease, angina, heart attack and any other kind of heart condition or disease); severe asthma; diabetes; arthritis-related conditions (including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia); adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions); severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
<p>If question #11 was answered as "Yes" (**), then the following questions are required:</p>		
<p>11a. Do you expect this condition to be of long-continued and indefinite duration AND substantially impair your ability to live independently?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
<p>11b. Do you have documentation of the disability and severity on file?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<p>11c. Are you currently receiving services or treatment for this condition?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
<p>12. Do you have a physical disability?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

CES Survey Part 2: Program Intake

Client Name / HMIS ID: _____

If question #12 was answered as "Yes" (**), then the following questions are **required**:

12a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
12b. Do you have documentation of the disability and severity on file?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
12c. Are you currently receiving services or treatment for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
13. Do you <i>currently</i> have a drug or alcohol problem?	<input type="checkbox"/> No <input type="checkbox"/> Alcohol* <input type="checkbox"/> Drug* <input type="checkbox"/> Both*	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

If question #13 was answered as "Alcohol", "Drug", or "Both" (**), then the following questions are **required**:

13a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
13b. Do you have documentation of the disability and severity on file?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
13c. Are you currently receiving services or treatment for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
13d. PATH Only: How was the client's drug and/or alcohol problem confirmed?	<input type="checkbox"/> Unconfirmed; presumptive or self-report <input type="checkbox"/> Confirmed through assessment and clinical evaluation <input type="checkbox"/> Confirmed by prior evaluation or clinical records		
14. Have you ever been told you have a learning disability or developmental disability?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

If question #14 was answered as "Yes" (**), then the following questions are **required**:

14a. Do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
14b. Do you have documentation of the disability and severity on file?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
14c. Are you currently receiving services or treatment for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
15. Do you feel you currently have a mental health problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

If question #15 was answered as "Yes" (**), then the following questions are **required**:

15a. Do you expect this condition to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
15b. Do you have documentation of the disability and severity on file?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
15c. Are you currently receiving services or treatment for this condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

CES Survey Part 2: Program Intake

Client Name / HMIS ID: _____

15d. PATH Only: How was the client's mental health status confirmed?	<input type="checkbox"/> Unconfirmed; presumptive or self-report <input type="checkbox"/> Confirmed through assessment and clinical evaluation <input type="checkbox"/> Confirmed by prior evaluation or clinical records	
15e. PATH Only: Does the client have a serious mental illness (SMI), and if so, how was it confirmed?	<input type="checkbox"/> No <input type="checkbox"/> Unconfirmed; presumptive or self-report <input type="checkbox"/> Confirmed through assessment and clinical evaluation <input type="checkbox"/> Confirmed by prior evaluation or clinical records <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
16. Have you been a victim of domestic violence or a victim of intimate partner violence?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
If question #16 was answered as "Yes" (**), then the following question is required :		
16a. If you experienced domestic or intimate partner violence, how long ago did you have this experience?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago <input type="checkbox"/> From six to twelve months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
16b. Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

CRISIS AND BRIDGE HOUSING - For all clients enrolling into CES Crisis and Bridge Housing projects

Question	Check Answer
17. Have you entered and been released from any of the following facilities in the past five years? (Choose any that apply)	<input type="checkbox"/> No, has not exited from any of these facilities in the past five years. <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If question #17 was answered as anything except No and Don't Know/Refused, then the following questions are required :	
17a. If so, which one have you most recently been released from? (Choose one)	<input type="checkbox"/> No, has not exited from any of these facilities in the past five years. <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
17b. Where was it located?	<div style="border-bottom: 1px solid black; width: 100%;"></div> <p style="text-align: right; font-size: small;">*SURVEYOR NOTE: Please choose a city from the list on page 10-12</p>
17c. And approximately when did you leave that institution? (Date)	<div style="border-bottom: 1px solid black; width: 100%;"></div>

ADULTS (18+) OR HEAD OF HOUSEHOLDS - For adults 18 and older or Head of Household < 18 years old, req'd questions shaded

Question	Check One Answer	Comments
18. Are you currently employed?	<input type="checkbox"/> No* <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

CES Survey Part 2: Program Intake

Client Name / HMIS ID: _____

If question #18 was answered as "No" (*), then the following question is required :		
18a. Are you.... (read options to the right)	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work	
If question #18 was answered as "Yes" (**), then the following question is required :		
18b. What type of employment do you have?	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal / sporadic (including day labor)	

WOMEN (15+) - Women aged 15 and older only

Question	Check One Answer	Comments
19. Are you pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> N/A	
If question #19 was answered as "Yes" (*), then the following question is required :		
19a. What is your due date?	____/____/____	

YOUTH (17 and under) - Head of Households aged 17 and under only

Question	Check One Answer	Comments
20. Did you run away from home or a foster care home? (Are you a runaway youth?)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> N/A	

TRANSITION AGE YOUTH (TAY) - Head of Households aged 16 to 24 only, required questions are shaded

Question	Check One Answer	Comments
21. Are you a current or former foster care youth?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
22. Have you ever been in the juvenile justice system?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
23. Have you ever been on adult probation?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
24. Which of the following best represents how you think about yourself?	<input type="checkbox"/> Straight <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

PATH ONLY - For adults 18 and older or Head of Household < 18 years old enrolling into a PATH funded project

Question	Check One Answer	Comments
25. Was the client determined to be eligible for PATH funded services and enrolled in PATH?	<input type="checkbox"/> No* <input type="checkbox"/> Yes	
If question #25 was answered as "No" (*), then the following question is required :		
25a. If not eligible to be enrolled, what is the reason?	<input type="checkbox"/> Client was found ineligible for PATH <input type="checkbox"/> Client was not enrolled for other reason(s)	
26. On what date was the client's eligibility and/or enrollment determined?	_____	
27. Is the client connected with SOAR?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not collected	

End of CES Survey Part 2



Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL
RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

VA Greater Los Angeles Healthcare Center
11301 Wilshire Blvd.
Los Angeles, CA 90073

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Rediscovery of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

CES Survey Supplemental: VA

Client Name / HMIS ID: _____

Instructions for surveyor (DO NOT READ ALOUD): Questions in this section do not need to be entered into HMIS, with the exception of SSVF programs. SSVF programs need to enter the questions highlighted in yellow, as well as the SSVF HP Targeting Criteria and the Use of Other Crisis Services sections.

Demographic (specific to HOMES)

7. Which race do you most strongly identify with?	9. What is your current marital status?	11. How Many full years of formal education do you have?	10. Child Custody
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian Or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Don't Know <input type="checkbox"/> Veteran Declined to Answer	<input type="checkbox"/> Married <input type="checkbox"/> Remarried <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Committed relationship/partnered <input type="checkbox"/> Declined to answer	<u>Elementary – Middle – High school</u> 1-2-3-4-5-6-7-8-9-10-11-12 <u>Junior/Comm/4-year College</u> 13-14-15-16 <u>Grad/Professional</u> 20	How many children under the age of 18 do you have? (include biological, adopted, step-children, and foster children?) _____ How many of your children are in your <u>legal custody?</u> (full or joint custody) _____

Military

12&13. In which branch of the military did you serve the longest? If equal time in two separate episodes, favor a combat era	14. In which component of the military did you serve the longest?	15&16. What was the rank status of your longest military service?	17. Are you currently serving in the military on active duty or active in the National Guard or reserves?
<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> Declined to answer (longest period of service) When did you enter military service? _____ When did you separate from service? _____ (overall military service if different) When did you enter military service? _____ When did you separate from service? _____	<input type="checkbox"/> Active Duty (Regular) <input type="checkbox"/> National Guard <input type="checkbox"/> Reserves <input type="checkbox"/> Declined to answer	<input type="checkbox"/> Enlisted <input type="checkbox"/> Warrant Officer <input type="checkbox"/> Commissioned Officer <input type="checkbox"/> Declined to answer What was the highest rank you achieved during your military tour(s) of duty? E-rating of 1-9 for enlisted W-rating of 1-5 for warrant officer C- rating of 1-10 for commissioned officer _____	<input type="checkbox"/> No <input type="checkbox"/> Active duty in military <input type="checkbox"/> Active in the reserves <input type="checkbox"/> Active in National Guard <input type="checkbox"/> Declined to answer

What was your discharge status from the military?

- | | | |
|---|---|--|
| <input type="checkbox"/> Honorable | <input type="checkbox"/> General under honorable conditions | <input type="checkbox"/> Under other than honorable conditions |
| <input type="checkbox"/> Bad Conduct | <input type="checkbox"/> Uncharacterized | <input type="checkbox"/> Dishonorable |
| <input type="checkbox"/> Veteran doesn't know | <input type="checkbox"/> Veteran refused | <input type="checkbox"/> Data not collected |

CES Survey Supplemental: VA

Client Name / HMIS ID: _____

18. Did you serve in the theater of operations for any of the following military conflicts?

(this item asks about service within the geographic proximity / region or the military conflict, not participation in combat)

World War II <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to answer <input type="checkbox"/> Doesn't know	Korean War <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to answer <input type="checkbox"/> Doesn't know	Vietnam War <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to answer <input type="checkbox"/> Doesn't know	Persian Gulf War (Desert Storm) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to answer <input type="checkbox"/> Doesn't know
Afghanistan (Enduring Freedom) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to answer <input type="checkbox"/> Doesn't know	Iraq (Iraqi Freedom 2003-12/18/2011) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to answer <input type="checkbox"/> Doesn't know	Iraq (New Dawn 12/19/2011-Pres.) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to answer <input type="checkbox"/> Doesn't know	Other Peace Keeping Operations or Interventions (Lebanon, Panama, Somalia, Bosnia, Kosovo, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to answer <input type="checkbox"/> Doesn't know

19. Did you ever receive hostile or friendly fire in a combat zone?

☐ No
☐ Yes
☐ Declined to answer

Living Situation

20. During the past 30 days (1 month), how many days did you sleep in the following kind of places?

Please make sure that the responses add up to 30 days

☐ Veteran declined to answer (if so skip question on current living places)

a. Housing owned by Veteran, <u>no</u> ongoing housing subsidy	
b. Housing owned by Veteran, <u>with</u> ongoing housing subsidy	
c. Housing rented by Veteran, <u>no</u> ongoing housing subsidy	
d. Housing rented by Veteran, <u>with</u> HUD-VASH voucher	
e. Housing rented by Veteran <u>with non</u> HUD-VASH housing subsidy	
f. Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO MOD Rehab)	
g. Staying or living in family member's room, apartment or house	
h. Staying or living in a friend's room, apartment or house	
i. GPD transitional housing	
j. Non-VA transitional housing for homeless persons	
k. Safe Haven (special transitional supportive housing or drop-in supportive service center for homeless SMI individuals)	
l. VA MH RRTP [all types: DCHV, CWT/TR, SA RRTP, PTSD RRTP, General RRTP]	
m. VA contracted residential treatment programs (ATU-HWH or HCHV contract)	
n. Non-VA residential treatment program	
o. Non-psychiatric hospital (acute care)	
p. Psychiatric hospital (acute care)	
q. Hotel or motel paid for <u>without</u> emergency shelter voucher	
r. Emergency shelter, including hotel or motel paid for <u>with</u> emergency shelter voucher	
s. Prison, jail	
t. Place not meant for habitation (outdoors, automobile, truck, boat)	

21& 22. In which one of the above locations did you sleep last night? (code a-t) Code "98" if Veteran declined to answer

Zip code of the location slept last night? (code N if don't know):	_____
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CES Survey Supplemental: VA

Client Name / HMIS ID: _____

23. Are you living with others at the location you slept last night?			
<input type="checkbox"/> No (skip questions below)		<input type="checkbox"/> Yes (does the household include)	
<input type="checkbox"/> Veteran declined to answer			
Spouse / significant other?	Children under 18 (list number)	Related adults (list number)	Unrelated adults (list number)
_____	_____	_____	_____

23e. What is your relationship to the head of household at the current location you are staying?	
<input type="checkbox"/> Self (head of household)	<input type="checkbox"/> Head of household's child
<input type="checkbox"/> Head of household other relation member (other relation)	<input type="checkbox"/> Head of household's spouse or partner
<input type="checkbox"/> Veteran declined to answer	<input type="checkbox"/> Other: non-relational member

24. Housing stability: How would you describe your current housing situation?		
<input type="checkbox"/> Literally homeless	<input type="checkbox"/> Imminent risk of losing housing	<input type="checkbox"/> Unstably housed / at risk of losing housing
<input type="checkbox"/> Stably housed	<input type="checkbox"/> Don't know	<input type="checkbox"/> Veteran declined to answer

27. What is the total amount of time, if any, that you have spent in jail or prison during your lifetime?		
<input type="checkbox"/> None	<input type="checkbox"/> Less than 1 month	<input type="checkbox"/> Between 1 month and 1 year
<input type="checkbox"/> More than 1 year	<input type="checkbox"/> Veteran declined to answer	

Employment and Income

28. Which best describes your employment pattern in the last 3 years?			
<input type="checkbox"/> Full time (40 hrs/wk)	<input type="checkbox"/> Full time (irregular)	<input type="checkbox"/> Part time (regular hours)	<input type="checkbox"/> Part time (irregular day work)
<input type="checkbox"/> VA CWT or other vocational work training	<input type="checkbox"/> Student	<input type="checkbox"/> Military service	
<input type="checkbox"/> Retired / disability	<input type="checkbox"/> Controlled environment (e.g. hospital, prison)	<input type="checkbox"/> Veteran declined to answer	

29. How many days did you work for pay in the past 30 days? Count participation in CWT/SE as days worked	
_____	<input type="checkbox"/> Veteran declined to answer

**** Look at CES general packet for Monthly Income, you may need to do a calculation to get monthly rate if pay rate is different****

Calculation for Monthly income		
Weekly = income x 52 / 12	Every other week = income x 26 / 12	Twice a month = income x 2
Monthly = income	Quarterly = income / 3	Yearly = income / 12

Los Angeles Area Median Income table								
Category	1 Person	2 Person	3 Person	4 Person	5 Person	6 Person	7 Person	8 Person
<input type="checkbox"/> 30% AMI	\$17,450	\$19,950	\$22,450	\$24,900	\$28,410	\$32,570	\$36,730	\$40,890
<input type="checkbox"/> 50% AMI	\$29,050	\$33,200	\$37,350	\$41,500	\$44,850	\$48,150	\$51,500	\$54,800

32. Do you have any significant outstanding debts?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (identify debt sources below)
<input type="checkbox"/> Veteran declined to answer	
<input type="checkbox"/> Housing loans	<input type="checkbox"/> Student Loans
<input type="checkbox"/> Child Support	<input type="checkbox"/> Other loans (personal, auto, etc.)
<input type="checkbox"/> Outstanding tax bills	<input type="checkbox"/> Credit card debt
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Medical expenses (self or dependents)
	<input type="checkbox"/> Fines or other legal oblig.

33. Do you currently have a representative payee or fiduciary?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
	<input type="checkbox"/> Veteran declined to answer

CES Survey Supplemental: VA

Client Name / HMIS ID: _____

Health

34. In the past 30 days, would you say your health has been....

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Veteran declined to answer

35. How would you describe the health of your teeth and gums?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Veteran declined to answer

36. Has a doctor or nurse ever told you that you have any of the following medical conditions?

HIV / AIDS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Hepatitis C	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Tuberculosis (TB) or + PPD	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Chronic Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Veteran declined to answer

36p. Does the Veteran have a disabling condition? ****IS NOT SELF-REPORT FROM THE VETERAN AND IS BASE ON THE INTERVIEWERS IMPRESSION****

Is this Veteran a homeless individual with a disability expected to be of long, continued and indefinite duration which substantially impedes his or her ability to live independently? A disability includes one or more of the following conditions: substance abuse disorder, serious mental illness, developmental disability, post-traumatic stress disorder, serious mental illness, cognitive impairments resulting from brain injury, or chronic physical illness / or disability mental health, substance abuse, or physical disorders. (NOTE: This item is based on the interviewer's impression and is not self-report from the veteran, if you are uncertain or are uncomfortable making that determination select omitted)

☐ No ☐ Yes ☐ Omitted

37. Do you use tobacco products?

☐ No ☐ Yes ☐ Veteran declined to answer

38-41. Questions regarding alcohol and substance use and feelings around use

In the past 30 days, how many days did you drink ANY alcohol?	
In the past 30 days, how many days did you have at least 5 drinks (for a man) 4 drinks (for a woman) [One drink is considered one shot of hard liquor (1.5 oz) or 12- ounce can/ bottle of beer or 5 ounce glass of wine]	
In the past 30 days, how many days did you use any illegal / street drugs or abuse any prescription medications? [i.e. Marijuana, cocaine or crack, methamphetamines, heroin or methadone, inhalants, etc..]	
In the past 30 days, how much were you bothered by craving or urges to drink alcohol or use drugs?	
<input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Considerably <input type="checkbox"/> Extremely	
<input type="checkbox"/> Veteran declined to answer	

42. Have you ever received professional treatment for alcohol or other substance use disorder?

☐ No ☐ Yes ☐ Veteran declined to answer

43. Have you ever been hospitalized for a psychiatric problem?

(do not include residential treatment or hospitalization for substance use problem)

☐ No ☐ Yes ☐ Veteran declined to answer

CES Survey Supplemental: VA

Client Name / HMIS ID: _____

Clinical Impressions (to be completed by a VA clinician) for HOMES

44. Which of the following treatment concerns apply to this veteran?		
Alcohol use disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Drug use disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Gambling problems or pathological gambling	<input type="checkbox"/> No	<input type="checkbox"/> Yes
schizophrenia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other psychotic disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bipolar disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Military related PTSD	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Non-Military related PTSD	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anxiety disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Affective disorder (including depression)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Adjustment disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nicotine dependence	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Organic brain syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Personality disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other psychiatric disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes

45-49. Treatment Needs and Participation			
Does the Veteran need psychiatric treatment at this time?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is the Veteran interested and willing to participate in psychiatric treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
Does the Veteran need substance abuse treatment at this time?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is the Veteran interested and willing to participate in substance abuse treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
Does the Veteran need medical treatment at this time?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is the Veteran interested and willing to participate in medical treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
Does the Veteran need case management?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is the Veteran interested and willing to participate in case management treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
Does the Veteran need assistance with family problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is the Veteran interested and willing to participate in treatment for family problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know

50&51. Safety	
Is this Veteran a danger to self or others?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is this Veteran in danger from others (e.g., gang violence, fleeing domestic viol.)?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Interviewer Information

52. Main Program Affiliation of interviewer	
<input type="checkbox"/> HUD-VASH <input type="checkbox"/> HCHV <input type="checkbox"/> GPD <input type="checkbox"/> VA MH RRTP <input type="checkbox"/> HCRV <input type="checkbox"/> VJO <input type="checkbox"/> SSVF <input type="checkbox"/> Other VA Affiliation: _____	

53. How was contact for this interview initiated (explain how you contacted or veteran was referred)?	
<input type="checkbox"/> By VA: _____ <input type="checkbox"/> By non-VA: _____ <input type="checkbox"/> By Criminal Justice System: _____ <input type="checkbox"/> By Family, Self or Other: _____ <input type="checkbox"/> Interviewer Omitted question	

CES Survey Supplemental: VA

Client Name / HMIS ID: _____

Veteran Table of Equivalent Military Ranks

Number	E Rating	Army	Air Force	Navy / CG	Marine Corps
1	E-1	Private	Airman Basic	Seaman Recruit	Private
2	E-2	Private E-2	Airman E-2	Seaman Apprentice	Private E-2 1 st class
3	E-3	Private 1 st class	Airman 1 st class	Seaman E-3	Lance Corporal
4	E-4	Specialist / Corporal	Senior Airman	Petty Officer 3 rd class	Corporal
5	E-5	Sergeant	Staff Sergeant	Petty Officer 2 nd class	Sergeant
6	E-6	Staff Sergeant	Technical Sergeant	Petty Officer 1 st class	Staff Sergeant
7	E-7	Sergeant 1 st class	Master / 1 st Sergeant	Chief Petty Officer	Gunnery Sergeant
8	E-8	Master / 1 st Sergeant	Senior Master Sergeant	Senior Chief Petty Officer	Master / 1 st Sergeant
9	E-9	Sergeant Major	Chief Master Sergeant	Master / Command Master Chief Petty Off.	Master Gunnery Serg. Or Sergeant Major

Table of Warrant Officers

Number	W Rating	Army	Air Force	Navy / CG	Marine Corps
1	W-1	Warrant Officer	No Warrant	Warrant Officer (no longer in use)	Warrant Officer
2	W-2	Chief Warrant Officer CW2	No Warrant	Chief Warrant Officer CWO2	Chief Warrant Officer CWO2
3	W-3	Chief Warrant Officer CW3	No Warrant	Chief Warrant Officer CWO3	Chief Warrant Officer CWO3
4	W-4	Chief Warrant Officer CW4	No Warrant	Chief Warrant Officer CWO4	Chief Warrant Officer CWO4
5	W-5	Chief Warrant Officer CW5	No Warrant	No Warrant	Chief Warrant Officer CWO5

Table of Commissioned Officer

Number	O Rating	Army	Air Force	Navy / CG	Marine Corps
1	O-1	Second Lieutenant	Second Lieutenant	Ensign ENS	Second Lieutenant
2	O-2	First Lieutenant	First Lieutenant	Lieutenant Junior Grade	First Lieutenant
3	O-3	Captain	Captain	Lieutenant	Captain
4	O-4	Major	Major	Lieutenant Commander	Major
5	O-5	Lieutenant Colonel	Lieutenant Colonel	Commander	Lieutenant Colonel
6	O-6	Colonel	Colonel	Captain	Colonel
7	O-7	Brigadier General	Brigadier General	Rear Admiral Lower Half	Brigadier General
8	O-8	Major General	Major General	Rear Admiral Upper Half	Major General
9	O-9	Lieutenant General	Lieutenant General	Vice Admiral	Lieutenant General
10	O-10	General	General	Admiral	General

HOMES Question Locations

1. Veteran's Name Survey Part 1 Page 1
2. Social Security Number..... Survey Part 1 Page 2
3. Date of Birth Survey Part 1 Page 2
4. Gender Survey Part 1 Page 7
8. Ethnicity..... Survey Part 1 Page 7
- 21a. Length of time at location slept at last night Survey Part 2 Page 2 Question 2
25. How long have you been homeless? Survey Part 1 Page 2 Question 4
26. How many Occasions of homelessness?..... Survey Part 2 Page 3 Question 4
- 26a. Total months homeless in past three years..... Survey Part 2 Page 4 Question 4a
30. Income in last 30 days..... Survey Part 1 Page 8 Calc. on Supp. Pg. 2
31. Non-Cash benefit last 30 days Survey Part 2 Page 1

CES Survey Supplemental: VA

Client Name / HMIS ID: _____

SSVF HP Targeting Criteria (Required in HMIS)

54. Referred by Coordinated Entry or a homeless assistance provider to prevent the household from entering an emergency shelter or transitional housing or from staying in a place not meant for human habitation.

☐ No (0 points) ☐ Yes

55. Major change in household composition (e.g., death of family member, separation/divorce from adult partner, birth of new child) in the past 12 months

☐ No (0 points) ☐ Yes

56. Rental Evictions within the Past 7 Years

☐ 4 or more prior rental evictions ☐ 2-3 prior rental evictions ☐ 1 prior rental eviction ☐ No prior rental evictions (0 points)

57. Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit

☐ No (0 points) ☐ Yes

58. History of Literal Homelessness (street/shelter/transitional housing)

☐ 4 or more times or total of at least 12 months in past three years ☐ 2-3 times in past three years
☐ 1 time in past three years ☐ None (0 points)

59. Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing

☐ No (0 points) ☐ Yes

60. Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property

☐ No (0 points) ☐ Yes

61. Registered sex offender

☐ No (0 points) ☐ Yes

62. At least one dependent child under age 6

☐ No (0 points) ☐ Yes

63. Single parent with minor child(ren)

☐ No (0 points) ☐ Yes

64. Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix)

☐ No (0 points) ☐ Yes

65. Any Veteran in household served in Iraq or Afghanistan

☐ No (0 points) ☐ Yes

66. Female Veteran

☐ No (0 points) ☐ Yes

67. HP applicant total points

68. Grantee targeting threshold score

Use of Other Crisis Services (Required in HMIS)

69. Number of visits to an emergency room in the past year

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

70. Approximate number of nights in jail / prison in the past year

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

71. Approximate number of nights spent in an inpatient medical facility in the past year

☐ Never ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-20 ☐ More than 20 ☐ Client Doesn't Know ☐ Client refused ☐ Data not collected

Last Name	First	Date of Birth (Mo/D/Yr)	Medical Record #	
			()	
Address	City	State	Zip Code	Phone #

HEREBY AUTHORIZES:

☐ DEPARTMENT OF HEALTH SERVICES

☐ Other: _____

Facility Name	Street Address	City, State	Zip Code
---------------	----------------	-------------	----------

To Release Protected Health information To:
Department of Health Services (DHS) Housing for Health Program.

TYPE OF RECORDS TO BE DISCLOSED		
<input type="checkbox"/> Ambulatory Clinic Records	<input type="checkbox"/> Lab & Pathology Reports	<input type="checkbox"/> Emergency Department Records
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Insurance Information
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Imaging Reports
<input type="checkbox"/> HIV/AIDS Test Results		
<input type="checkbox"/> Other, specify:		

Housing for Health will obtain up to five (5) years of medical information unless otherwise specified:
_____ (Date/Timeframe)

The following information will only be released if you give your specific permission by providing your initials to the following:

_____ I agree to the release of information pertaining to mental health diagnosis or treatment that are otherwise protected under Welfare & Inst. Code 5328, excluding psychotherapy notes defined by 45 CFR 164.501

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)



T-LAC101422

FILE IN MEDICAL RECORD

THE PURPOSE OF THE DISCLOSURE IS: To permit Housing for Health and their contractors 1) to determine eligibility for Housing for Health resources; 2) to provide the minimum necessary protected health information to community based organizations, who are contracted with DHS to arrange for housing, case management and integrated and coordinated services; 3) to assist me in the application and receipt of any public benefit which I may be otherwise entitled to; and 4) to provide me with on-going case management services.

NOTICE

Department of Health Services and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- I understand this authorization is voluntary and will not affect my ability to obtain treatment. However, without a signed Authorization, DHS Housing for Health may not have adequate information to determine my eligibility for housing services.
- I am entitled to receive a copy of this Authorization.
- I may revoke this authorization at any time, provided that I do so in writing and may use the form below.
- The revocation will take effect when DHS receives it, except to the extent that DHS or others have already relied on it.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires five (5) years from the date of signing below.

AUTHORIZATION

I have had the opportunity to review this and understand what it says. By signing, I agree that it accurately reflects my wishes and I affirm that I have not place any restriction on the release of any information authorized for release by this Authorization.

Signature of Patient/Legal Representative

Print Name

Date: ____/____/____

If signed by other than patient, state relationship and authority to do so:

Witness:

Print Name:

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)



T-LAC101422

FILE IN MEDICAL RECORD

**HOUSING FOR HEALTH AUTHORIZATION FOR USE AND
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

PAGE 2 OF 3

LAC101422 (4-16)

Right to Revoke This Authorization – I understand that I may revoke this Authorization for Housing for Health at any time by giving written notice of my revocation to the DHS facility at the address listed below. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to the following address:

I also understand that a revocation will not affect the sharing of information done in reliance of this Authorization prior to it's being revoked.

REVOCATION OF AUTHORIZATION

Signature of Patient/Legal Representative: _____

If signed by other than patient, state relationship and authority to do so:

DATE: ____/____/____

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)



T-LAC101422

FILE IN MEDICAL RECORD



HOUSING FOR HEALTH (HFH) HOUSING REFERRAL FORM

HOUSING
FOR
HEALTH

Instructions

To access both Permanent Supportive Housing and Interim Housing, please fax the completed HFH referral packet to the HFH Access Team at **(213) 482-3395**. For Permanent Supportive Housing please complete the 2 page referral form and the signed consent form. If you would like to access Interim Housing (Stabilization Housing/Recuperative Care) please complete the 2 page referral form, the signed consent and Attachment A.

Date: _____

Referral Type (check all that apply): ☐ Permanent Supportive Housing ☐ Interim Housing: Stabilization Housing and/or Recuperative Care

Referring Agency/DHS Facility:	Staff Name/Title:
Office #:	Cell/Pager #:
Alternate Staff:	Office/Pager #:

IDENTIFYING INFORMATION			
First Name:	Middle Name:	Last Name:	
Aliases:	DOB:	Social Security #:	Medical Record #/Client ID #:
Does applicant have any of the following ways of being contacted (check all that apply and specify below): <input type="checkbox"/> None			
<input type="checkbox"/> Phone: _____ <input type="checkbox"/> Alternate Phone/E-mail: _____			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (M to F) <input type="checkbox"/> Transgender (F to M)	Ethnicity: <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know / Decline to state	Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black, African/African-American <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Don't know / Decline to state	
Residency Status: <input type="checkbox"/> US Citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> None of Above	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Can applicant communicate in English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the applicant have the following: Proof of legal residency: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure Current ID: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure Social Security Card: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		Has the applicant ever served in the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No Discharge status: <input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable <input type="checkbox"/> Other: _____	

HOMELESS STATUS	
Is applicant HOMELESS (see worksheet)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is applicant CHRONICALLY HOMELESS (see worksheet)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge Destination or Current Location:	Length of HOMELESSNESS? _____ yr _____ mo
Specify geographical housing preference (if known):	VI-SPDAT score? <input type="checkbox"/> Yes <input type="checkbox"/> No
If applicant <u>CANNOT</u> be housed in a specific geographic location, list area:	If Yes, score(if known): _____

FAMILY COMPOSITION		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married	Household Size (#):	# of adults to be housed in addition to applicant? _____ # of minors to be housed? _____
For minors to be housed with applicant:		
Gender	DOB	Relationship to Applicant / Other Adult
Service Animal/Pets		
Type	Size/Weight	Describe (e.g. service animal or pet, special needs required for animal, etc.)

HOUSING FOR HEALTH (HFH) HOUSING REFERRAL FORM

Patient First & Last Name: _____ MRUN # _____

FINANCIAL

Applicant's Income (check all that apply): ☐ No Income

- | | |
|---|--|
| <input type="checkbox"/> General Relief (GR) \$ _____/month | <input type="checkbox"/> CalFresh (Food Stamps) \$ _____/month |
| <input type="checkbox"/> Supplemental Security Income (SSI) \$ _____/month | <input type="checkbox"/> Unemployment \$ _____/month |
| <input type="checkbox"/> Social Security Disability Insurance (SSDI) \$ _____/month | <input type="checkbox"/> Employed \$ _____/month |
| <input type="checkbox"/> Veteran's Administration Benefits \$ _____/month | <input type="checkbox"/> Other (specify) _____ |

MEDICAL INFORMATION

Health Insurance (check all that apply):

- ☐ Medi-Cal ☐ Medicare ☐ Private ☐ None ☐ Unknown

Health Insurance Carrier (e.g. HealthNet/LA Care): _____

Primary Care Provider/Medical Home (if known):

Clinic: _____ / Provider: _____

Specify date of last visit (if known): _____

Specify any chronic medical conditions:

Mobility

Applicant's physical mobility/accessibility needs (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> No mobility limitations | <input type="checkbox"/> Uses motorized wheelchair -- Has motorized wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Cannot climb stairs | <input type="checkbox"/> Uses manual wheelchair-- Has manual wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Uses walker/cane/crutches | <input type="checkbox"/> Needs assistance with transferring in/out of wheelchair |
| <input type="checkbox"/> Needs ramp access | <input type="checkbox"/> Other _____ |

Medical Needs

Does the applicant need any assistance in the following areas (check all that apply):

- ☐ Breathing (supplemental oxygen)
- ☐ Incontinence Issues
- ☐ Taking Medications
- ☐ Activities of Daily Living (hygiene/grooming)
- ☐ Independent Living Skills (cooking, cleaning)
- ☐ Other _____
- ☐ None

Specify type of assistance needed for any of the areas checked at left:

MENTAL HEALTH

Cognitive Impairments (check all that apply): ☐ None

- ☐ Developmental Delays ☐ Dementia ☐ Traumatic Brain Injury

Mental Health Diagnosis (check all that apply): ☐ None

- ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ Personality Disorder

☐ Other _____

Specify behaviors related to Cognitive Impairments/Mental Health Issues:

Does applicant have a mental health provider (If Yes, specify below)? ☐ Yes ☐ No ☐ Unsure

Agency: _____

Contact Person/Number: _____

SUBSTANCE USE DISORDER

LEGAL HISTORY

	Past Use	Current Use	Date of Last Use	
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		Has the applicant been convicted of any of the following (check all that apply): <input type="checkbox"/> Arson <input type="checkbox"/> Production of methamphetamines <input type="checkbox"/> Sex offender <input type="checkbox"/> Violent crime (specify): _____ <input type="checkbox"/> Warrants (specify): _____
Benzodiazepines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Opiates	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Methadone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
IV use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other (specify below):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		Specify dates for any areas checked above: _____

Please provide any additional information that will help HFH staff and/or its partners successfully find housing for the applicant:

HOUSING FOR HEALTH (HFH) REFERRAL FORM
ATTACHMENT A

Medical Background for Interim Housing Referrals
Stabilization Housing and/or Recuperative Care Services

Instructions

For access to Interim Housing, please fax the completed HFH referral packet to the HFH Access Team at **(213) 482-3395**, including Attachment A, the signed consent form, and documentation on the patient's TB clearance (recent PPD or chest x-ray within the last 12 months).

Date: _____

Referring Agency/DHS Facility:		Staff Name/Title:		Contact #:	
Applicant First Name:		Middle Name:		Last Name:	
Aliases:		DOB:	SS#:		Medical Record #:
<p>Check any of the following medical needs:</p> <p><input type="checkbox"/> Wound Care <input type="checkbox"/> Recovery from surgical procedure <input type="checkbox"/> Additional time to recuperate from illness and/or injury</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>Provide specific information regarding medical care such as Wound Care Needs (location, size, depth), Recent Surgical Procedures, Any Infections/Illnesses/Injuries or any other relevant medical information (e.g. IV use for 2 weeks):</p> <p>_____</p> <p>_____</p>					
<p>Tuberculosis status:</p> <p>Last PPD or chest x-ray and result: _____</p> <p>Any homeless person with a new cough, change in cough for 3 weeks or with symptoms suggestive of pneumonia or TB must have a chest x-ray. Any infiltrate or unexplained pleural effusion should be viewed as suspicious for TB. These patients will not be admitted to Housing for Health until 3 AFB smears are negative, or the CXR shows signs of clearing on an antibiotic regimen, or the patient demonstrates clear clinical improvement (resolution of fever for at least 24 hours or absence of a productive cough) after 72 hours on antibiotics.</p> <p>Persons with AIDS are at greater risk for TB, and often the CXR can be negative. Any homeless patient with AIDS with a productive cough is required to have 3 negative AFB smears REGARDLESS OF CXR FINDINGS and be cleared by the HFH physician prior to admission.</p>					
<p>Specify any additional medical discharge instructions (e.g. diet, activity restrictions), behavioral instructions (e.g. monitoring, angry when touched), or any other concerns:</p> <p>_____</p> <p>_____</p> <p>_____</p>					
<p>Is applicant willing to reside in a communal living environment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>"YES" means the applicant understands that placement could possibly include sharing common areas and facilities (e.g. bedroom space, bathroom facilities, showering) and agrees to be placed in such a facility.</p>					

Patients being referred to Interim Housing from a DHS facility will need to provide the patient with the all of the following items listed below and fax all the items marked with an asterisk (*) to the HFH Access Team at (213) 482-3395 – Attn: Interim Housing **PRIOR** to interim housing admission:

- ☐ *Medication list (with dosage & frequency instructions)
- ☐ 30-day supply of all medications and medical supplies (if applicable)
- ☐ *List of the patient's follow-up appointments
- ☐ *Copy of their discharge summary sheet (if coming from the ER or inpatient setting).

Patient First & Last Name: _____ MRUN # _____

Housing for Health Authorization to Release/Share Information

I agree to allow the Department of Health Services (DHS) and/or HFH Service Partners (a provider that has a contract or agreement with Department of Health Services whom the department has deemed appropriate for the patient), to share my information with each other for the following purposes:

1. DHS and/or HFH Service Partners may use my information to provide me with case management, integrated and/or coordinated services, and to assist in providing temporary and/or permanent housing opportunities.
2. DHS and/or HFH Service Partners may use or disclose my information for research purposes, subject to the requirements of applicable law, and to make recommendations on policies to improve services for people experiencing homelessness.
3. I understand that if I sign this agreement, I voluntarily consent and hereby authorize DHS to release and disclose information about me to HFH Service Partners.
4. I understand that if I sign this agreement, I voluntarily consent and hereby authorize HFH Service Partners to release and disclose information about me to DHS.
5. I understand and agree that I will receive no money or other benefits from the County of Los Angeles, DHS, HFH Service Partners or any other party as a result of consenting to the release of such information.
6. I agree to release the County of Los Angeles, DHS, HFH Service Partners, its agents and employees from any liability whatsoever, including for injuries, damages and losses, known or unknown, resulting from sharing the information with other County departments, homeless service providers and housing locators, with whom the County has relationships.
7. I acknowledge that before signing this consent for release agreement, I have carefully read and fully understand its terms. If I am unable to read, the person asking me to sign this form has read and explained all of the items/terms listed in this agreement.
8. This agreement shall become effective on the date provided below and will **expire one year** from the date below.

Date

Applicant Signature

Print Applicant Name

Referring Staff Signature

Print Referring Staff Name

CES Supplemental: Housing Preferences

Client Name / HMIS ID: _____

I'm going to ask you some questions about housing. Just to be clear, this is not a housing application. These are just questions to get a better idea of what kind of housing might be right for you.

Questions To Assist With Housing Match

Question	Check One Answer	Comments
1. If you were able to locate housing, do you have money saved up for move-in or housing?	<input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Unsure	
2. How many adults will this unit need to accommodate including yourself?	<input type="checkbox"/> 1 <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 4 <input type="checkbox"/> 8 or more	
3. Have you ever been evicted from housing or abandoned a unit, of which your name was on the lease?	<input type="checkbox"/> Yes** <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Unsure	
If question #3 was answered as Yes (**), then the following question is required :		
3a. If yes, approximate month and year of last eviction: <i>If you are unsure of the day, please select the first day of the month.</i>	_____ / _____ / _____	
4. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Unsure	
5. Have you ever been convicted of arson?	<input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Unsure	
6. Have you been in jail or prison in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Unsure	
7. Are you currently on probation or parole?	<input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Unsure	
8. Do you have a pet?	<input type="checkbox"/> Yes** <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Unsure	
If question #8 was answered as Yes (**), then the following question is required :		
8a. Is it a certified service animal or emotional support animal?	<input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Unsure	
9. Are there other requirements or needs that we should be aware of about permanent housing? <i>*check all that apply*</i>	<input type="checkbox"/> 1st Floor <input type="checkbox"/> Elevator <input type="checkbox"/> Upper Floor <input type="checkbox"/> Private Bathroom <input type="checkbox"/> Kitchenette <input type="checkbox"/> Public Transit <input type="checkbox"/> Accessible entrance <input type="checkbox"/> Wheelchair accessibility <input type="checkbox"/> Rails in bathrooms <input type="checkbox"/> Other:	

CES Survey: Contact Sheet

Thank you for completing this survey. Your answers will help us better understand your health and housing needs and the needs of our community, and may help us make better referrals for you in the future.

For more information about the Coordinated Entry System or this survey, please contact:

SPA ___ Community Coordinator: _____

Phone: _____

Email: _____

Address of regional access center: _____

Follow up contact (if applicable):

Outreach Worker/Housing Navigator: _____

Phone: _____

Email: _____